

FLORIDA MEDICAID PRIOR AUTHORIZATION: Pharmacy - Miscellaneous

Maximum length of approval = 12 months or less. Note: Form must be completed in full. An incomplete form may be returned.

FAX this completed form to 1-833-546-1507 OR Mail request to Pharmacy Services Prior Authorization Dept. 5 River Park Place East, Suite 210, Fresno, CA 93720. Call 1-866-399-0928 to request a 72-hour supply of medication. Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

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Drug: Quantity:											Dosage and Frequency of Dosing:																		
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Previous Therapy (include drug, dose, and duration): 1. Date of trial:																													
2. Date of trial:																													
Reason for Discontinuing Previous Therapy:																													
		Allergic reaction, contraindication, and/or drug interaction (please specify all and submit progress notes to support):																											
	7	Therapeutic Failure (please provide lab data, discharge summaries, or progress notes):																											
Cont	inua	atio	n of	The	rapy	/ :																						_	
	Patient has a documented positive response to therapy (progress notes required):																												
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